Life Insurance Company of North America
Personal Accident Insurance

Policy Number: OK-4509
Policy Holder: Placer County

Last Name , First , Middle , ,		
Date of Birth / /	**Social Security Number** - -	**Phone Number** ( ) -
Address: **Street**	**City**	**State** **Zip**

ENROLLMENT

Select Coverage	**Benefit Amount**	**Cost**
☐ Employee Basic	Coverage amount $10,000	$ 0
☐ Supplemental Employee	Coverage amount $ _____	$_____
☐ Spouse/Registered Domestic Partner	Coverage amount $_____	$_____
☐ Child/ren	Coverage amount $_____	$_____

$_____ Total biweekly

My Beneficiary: (Print full name)	Birth Date	SSN#	**Relationship:**
	Birth Date	SSN#	**Relationship:**
	Birth Date	SSN#	**Relationship:**

You will be your family members' beneficiary unless you tell us differently.

I enroll and authorize my employer to deduct the premiums from my earnings. **Signature of insured or assignee:**	**Date:** / /

☐ **DECLINATION –** Check here and sign above if you do not want this coverage

CHANGE IN ENROLLMENT

NAME CHANGE

Change name to:

First **Middle initial** **Last**

BENEFICIARY CHANGE

See instructions

My Beneficiary(s): (Print full name)	Birth Date	SSN#	Relationship:
	Birth Date	SSN#	Relationship:
	Birth Date	SSN#	Relationship:

If more that one beneficiary in a primary or contingent class is named, all beneficiaries or survivor(s) in each class will share equally unless otherwise stated above

Signature of insured or assignee:	**Date:** / /
Witness signature:	
Above change validated: / /	**By:**